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ABSTRACT

This pamphlet is a capsule commentary on the Kirschner field research project which attempted to obtain a greater understanding of Head Start's role in influencing community health and educational programs. The general goals for Head Start are summarized and expanded to include objectives unique to this survey. Specifically, the Kirschner project hoped to illuminate the general question of how to achieve changes in local institutions utilizing a nationwide educational innovation as the intervention strategy. Field work in 42 communities representing high, medium, low, and no levels of Head Start activity identified four kinds of changes consistent with Head Start programs and policies. The 1,496 changes, when pinpointed, could be distributed into four categories: (1) increased decision-making, (2) greater employment, (3) greater educational emphasis, and (4) modification of health services. Although institutional changes took place in a complex social environment, Head Start did seem to have a generally positive influence in modifying local institutions so they became more responsive to the needs and desires of the poor. A complete report of this research project is available as PS 003 672. (WY)

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KIRSCHNER ASSOCIATES, INC.

U. S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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A NATIONAL SURVEY OF THE IMPACTS OF HEAD START CENTERS ON COMMUNITY INSTITUTIONS

Contract No. B89-4638

SUMMARY REPORT

Prepared for

Project Head Start
Office of Child Development
U.S. Department of Health, Education, and Welfare

PS004178

May 1970

The conclusions and recommendations in this report are those of the Contractor and do not necessarily reflect the views of the U.S. Department of Health, Education, and Welfare or any other agency of government.

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Dr. Edith Grotberg
Dr. Lois-ellin Datta

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All of the many persons above cited were helpful in this project. However, Kirschner Associates, Inc., and its central project staff are responsible for the conduct of this project and for the data analysis and conclusions presented in this report. The principal staff members responsible for this assignment are Dr. Robert G. Hayden, Mrs. Lois Mock, Mrs. Nancy Sandusky, Miss Sherrie Simonds, Mr. Richard L. Moss and Mrs. Jeanne Schpok.

SUMMARY

OBJECTIVES OF THIS PROJECT

Project Head Start has a number of goals designed to improve the opportunities and achievements of the children of the poor. These goals have been stated as follows:[1]

--Improving the child's physical health and physical abilities.

--Helping the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity, and self-discipline.

--Establishing patterns and expectations of success for the child which will create a climate of confidence for his future learning efforts.

--Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems.

--Developing in the child and his family a responsible attitude toward society, and fostering constructive opportunities for society to work together with the poor in solving their problems.

--Increasing the sense of dignity and self-worth within the child and his family.

Most research concerning Head Start has focused on determining how successful the program has been in helping children with whom it works. It must be recognized that Head Start is also vitally

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[1] Report prepared for the Office of Economic Opportunity by a Panel of Authorities on Child Development, Robert Cooke, Chairman. 1964 GP 923-454.

concerned with influencing the environment in ways deemed beneficial to the children of low-income families. This is inferred from many of the Head Start goals noted above which cannot be accomplished solely as a result of the association of a child or his family with Head Start. For these goals to be achieved it is obviously necessary that the philosophies, practices, and activities of other community institutions become more sensitive and responsive to the needs of the poor and their children. The research effort described in this report deals with this aspect of Head Start, i.e., the impacts of Head Start on the community and particularly selected crucial community institutions.

More specifically, the objectives of the research project described in this report are as follows:

1. To determine if there have been changes in local educational and health institutions relevant to the objectives of Project Head Start;

2. To determine if local Head Start centers were influential in bringing about relevant changes in community institutions;

3. To analyze how Head Start was involved in the institutional change process;

4. To describe the different impacts on community institutions of various Head Start characteristics and approaches.

Thus, this project attempts to obtain a greater understanding of Head Start's role in influencing changes in community institutions. More broadly, it is hoped that it will illuminate the general question of how to achieve changes in local institutions utilizing a nationwide educational innovation as the intervention strategy.

ORGANIZATION OF PROJECT

This project was undertaken during the period from July 1968 through January 1970 and was divided into a preliminary phase, a Phase I and a Phase II. During the preliminary phase the basic project design was developed and informal investigations were conducted to determine if local institutions had changed in ways consistent with Head Start goals. The informal preliminary investigation indicated that the institutional changes that had occurred recently and that appeared to have been stimulated by Head Start were in two major areas: health and education.

Phase I of the project, which followed, was designed to determine systematically if community health and educational institutions had changed in specific ways relevant to Head Start. To make this determination, field research was undertaken in a national sample composed of 58 communities with full-year Head Start programs. The final phase of the field work was conducted in 42 of the original 58 communities. In these 42 communities, a total of 47 specific changes in health and educational institutions were studied intensively. These investigations were to determine how Head Start had been involved in bringing about these changes. Systematic field investigations were also conducted in seven communities with little or no exposure to Head Start and the results were compared with similar communities that had had more extensive Head Start experiences.

By the fall of 1968, when the field research was started, summer Head Start programs had been offered for three or four years but most of the full-year programs had been in operation scarcely a year. Further, the field work was not designed to identify all possible impacts of Head Start. Consequently, to measure the impacts of Head Start by reference solely to the number of changes identified in this project would be inconsistent with the intent of the project as well as an underestimate of the influence of Head Start.

FINDINGS

Identification of Relevant Institutional Changes

The field work was designed to identify changes in local educational and health institutions that seemed most consistent with Head Start policies and programs including:

--Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

--Increased institutional employment of local persons in paraprofessional occupations.

--Greater educational emphasis on the particular needs of the poor and of minorities.

--Modification of health institutions and practices to serve the poor better and more sensitively.

Head Start itself involves parents in its programs, employs neighborhood people in paraprofessional roles, is concerned with the special needs of the poor and of minorities, and emphasizes better medical services for Head Start families. Thus, the field work sought to determine if other institutions, particularly educational and health institutions, had changed to reflect these same concerns.

Institutional changes consistent with Head Start goals and philosophies were identified in all of the communities investigated. A total of 1496 changes were identified in the 58 communities studied. The number of institutional changes per community varied from 14 to 40. In over half of the communities surveyed, more than 25 changes were identified. In no cases were there only isolated instances of change. Thus, while it cannot be said at this stage of the analysis that Head Start caused these prevalent institutional changes, it can be seen that changes of a type desired by Head Start have generally occurred in substantial numbers. Reference to the

comparison communities (those without Head Start centers) reveals that almost no relevant institutional changes were identified.

An effort was made to identify the number of educational and health changes and to determine their relative distribution by community. Of the total of 1496 changes identified in the 58 communities, 1055 were educational in nature and 441 were classified in the health category. There are no cases where there are solely health or educational changes in a community. As might be expected, the distribution of changes by community is consistent with the overall finding that about 80 percent of the changes identified are in the educational area. The data thus indicate not only that community changes consistent with Head Start goals have occurred on a widespread basis but that these changes are prevalent in both educational and health fields, two of the areas of predominant Head Start concern.

As previously indicated, certain types of institutional changes are considered particularly responsive to Head Start. There is some overlap between this categorization, which follows, and between the somewhat broader distinction between educational and health changes. The 1496 changes identified are distributed as indicated on the following table.

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TABLE S-1

Number of Institutional Changes in
Each of Four Categories

Category of Institutional Change	Frequency	Percent of Total
Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities	305	20.3
Greater employment of local persons in paraprofessional occupations	51	3.4
Greater educational emphasis on the particular needs of the poor and of minorities	747	50.0
Modification of health services and practices to serve the poor better and more sensitively	393	26.3
Totals	1496	100.0

In most cases all four types of changes have been identified in a community. Never were fewer than three types of change reported. It is concluded, therefore, that a variety of the important Head Start goals and concepts have been widely adopted. The examples below indicate the types of changes that occurred in these categories.

Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

--In a small southwestern village a grass-roots organization has formed a group of Spanish-speaking parents to pressure for changes in school policies and practices. An issue currently in focus is the school system's lunchroom

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Increased involvement of the poor with institutions, particularly at decision-making levels and in decision-making capacities.

--In a small southwestern village a grass-roots organization has formed a group of Spanish-speaking parents to pressure for changes in school policies and practices. An issue currently in focus is the school system's lunchroom

regulation against students bringing rather than buying lunch. (Many cannot afford the lunches.)

--In the South, low-income people in one community have recently increased their use of public health services and have voiced their opinions regarding improvements needed in the health institution's practices and policies. In response, the health institution has desegregated its waiting room, assigned patients to specific doctors, and opened the facilities one evening a week.

Employment of paraprofessionals.

--A midwestern school system has employed indigenous teacher aides in poverty neighborhoods to tutor children after school.

--A large city school system utilizes paraprofessionals almost entirely in its summer recreation project in the ghettos.

Greater educational emphasis on the particular needs of the poor and minorities.

--Low-cost (and even free) meals are now available to needy youngsters in many communities. Some schools serve a nutritious breakfast, lunch, and an afternoon snack.

--A midwestern school system has placed social workers in ghetto neighborhood schools. Most of these new staff members are black.

Modification of health services and practices to serve the poor more effectively.

--In the South, a mental health facility has been desegregated and actively reaches out to black neighborhoods through churches and anti-poverty programs.

--In Appalachia, a visiting nurse program has been established for the purpose of providing routine nursing care to the sick in an area with a paucity of medical services.

The Impact of Head Start on Community Institutions

Institutional changes took place in a complex social environment generally characterized by the existence of a wide variety of

programs and forces. Consequently, it is exceedingly difficult to isolate particular institutional changes and attribute them solely to the existence of Head Start. Nevertheless, the evidence collected in this project indicates that:

1. Head Start had a positive influence in almost all (44 out of 47) of the changes investigated in depth.

--A Head Start center in a northern industrial city was responsible for developing an after-school recreational activity program in some of the ghetto-area schools. Head Start staff and parents organized this program originally because of their realization that school-aged Head Start siblings had no place to play after school hours. At that time the program was held in the Head Start centers with parents alternating as volunteer supervisors. As the program gained in popularity in the poor neighborhoods, non-Head Start families became interested and Head Start staff requested that the school system take over the program so that it could be enlarged.

--An innovative preventive-health-care project was initiated by a Head Start Policy Advisory Committee in a northeastern industrial city. The committee formed a consumer cooperative which purchases fresh fruits and vegetables in bulk, packages the goods, and distributes them to families in the ghetto. Much of the work involved in establishing this project was done by the Head Start parents themselves. All of the work involved in purchasing the goods, taking orders from families, and packaging and distributing the food is done by Head Start parents. Assistance in working out some of the technical details was provided by local university faculty members, but most of the credit for establishing this highly successful project belongs to the Head Start parents.

--A health-care clinic in an eastern industrial city represents the culmination of many months' effort by Head Start parents, university medical students and faculty members, and the public health department. The concept for this clinic appears to have been the brainchild of Head Start parents and other members of the Head Start Parent Advisory Committee.

--The processes leading to curricular changes in a southern school system appear to have originated in a black PTA organization whose members found reason to criticize the content and relevance of classroom work. The parents requested a study of the curricula, which was conducted by professionals in the educational field and presented to the school system with recommendations for changes. These changes were subsequently implemented by the school system.

--Head Start parents in a western city allied themselves with local black activist groups to bring about specific changes they wanted in the school system. Head Start staff and delegate agency people organized parents and encouraged them to press for changes such as hiring Negro teacher aides and providing free hot lunches for needy children.

2. Communities without the Head Start experience had fewer and less marked changes in their educational and health institutions.

--In one small northern community, which has no Head Start, the prevailing general attitude was that the poor were no different from the more affluent--"just lazier." Private physicians alleged that the poor seemed able to afford everything except good medical care for their children, and that if these parents budgeted their money more efficiently, they could afford the health care their children needed.

In this conservative town, the general opinion reported was that each family should pay for what it receives, including medical care. No public health programs existed; nor was there a public health nurse, an immunization program, or a maternity or well-baby clinic.

--In a southern community, which has no Head Start program, a handful of dedicated persons was found to be working on educational and health problems, but with only partial success at best. One program, supported by a local Negro church, was designed for black preschool children. It was financed almost entirely by parents of the children who paid $1.50 per week for supplies and packed lunches for the children to take to the "school," located in the church building. The program was run entirely by the volunteer efforts of its two founders, an elderly

retired black school teacher and a young black minister. It was apparently the only community involvement effort of the poor in this town, and the only educational program available to black preschool youngsters.

3. Factors other than Head Start were frequent, important contributors to institutional change during the period studied. One of these factors was the concurrent availability of Elementary and Secondary Education Act (ESEA) funds and other federal funds for programs to help the disadvantaged. In many cases where Head Start was instrumental in encouraging the institutional changes noted, the availability of these federal funds to local institutions was also crucial.

--One of the best examples of successful attempts by Head Start to generate institutional change is provided by a school system in a predominantly black southern community which now operates a comprehensive health clinic. The clinic is financed almost entirely by federal funds. This school system has altered its traditional role of educator to include that of health-care provider as well. The idea for a health-care facility was generated by a Head Start nurse who realized the need for such a program after examining the Head Start enrollees, most of whom exhibited symptoms of chronic disease and malnutrition. Many had never been examined by a doctor. The nurse presented these facts to public health and school officials and requested their help in finding a solution to the problems. Together they worked out a plan whereby the school system would apply for federal funds to establish and operate a health clinic for children.

--In a northern community an "Extended Kindergarten" program was developed for operation in two low-income area schools. Techniques and curricula used in the new program are based on the Head Start model. The school official responsible for originating this program reported that she had seen the need for it long ago, but had not been able to develop the program until federal funds became available.

Head Start's Role in the Process of Change

To move beyond the conclusion that Head Start has influenced local educational and health institutions, an effort was made to increase understanding of how this influence was generally exerted.

For purposes of this analysis, the process of institutional change has been divided into seven stages, each of which is described by example below:

1. Background Stage

--The school system began to concern itself with malnutrition of the poor children--a rather universal condition among the Head Start children that came to light during their physical examinations. School officials' awareness of this problem led them to apply for funds to implement hot meal and snack programs in the schools.

2. Idea - Proposal Stage

--The persistent efforts of one individual--a Head Start director--were reported to have been solely responsible for bringing about an enlargement of the health department's immunization program. A large proportion of the children who enrolled in Head Start had never had immunizations--a fact discovered during the children's Head Start physical examinations. This discovery instigated the Head Start director's campaign for an enlarged immunization program that would serve a greater number of children and include immunizations against smallpox, measles, and polio as well as the DPT series.

3. Support for Change Adoption

--In a western community, the large Spanish-American segment of the population had felt discrimination by the school system for many years. Furthermore, the Spanish-Americans felt that the school system's refusal to recognize and cooperate with Head Start was an example of its long-evidenced disinterest in educating Spanish-Americans. The Head Start parents allied themselves with other active minority-group organizations and together they campaigned for a slate of school

board candidates who were sensitive to their problems. Their efforts were successful, and they were able to elect a majority of the school board.

4. Authorization Stage

--In a small southern town, the health department requested that it be allowed to administer the medical component of Head Start. The stated purposes behind this request were that it would enable the health department to centralize all records on the children and to have more contact with the parents. Although originally reluctant to approve the measure, OEO Regional officials authorized it after much negotiation and discussion with local Head Start and health personnel. The additional funds made it possible for the health department to hire additional staff members.

5. Resource - Fund Provision

--In a large midwestern city, the Head Start program provides training for paraprofessionals employed in various public health services.

6. Execution Stage

--Many of the kindergarten teachers in a large city school system in the West have modeled their classroom scheduling and programming after the Head Start program. Most of the kindergarten teachers who made these changes were former Head Start staff members who had successfully used the new, less rigid techniques with Head Start children. When these Head Start staff members became a part of the regular school system they took their ideas and methods with them.

7. Support During Change Execution

--Head Start children, siblings, and parents in the city are frequently referred by Head Start to the new health-care programs in the community for medical treatment, family planning consultation, dental care, prenatal care, and immunizations.

In 94 percent of the institutional changes studied, Head Start was involved in one or more stages of the change process. In a majority of the changes, Head Start was involved at three or more

stages as indicated in Table S-2. It appears from these data that when Head Start was involved in the change process, its involvement tended to go beyond an intervention at only one point in time when one type of assistance was needed. A continuing involvement seems to be indicated.

TABLE S-2

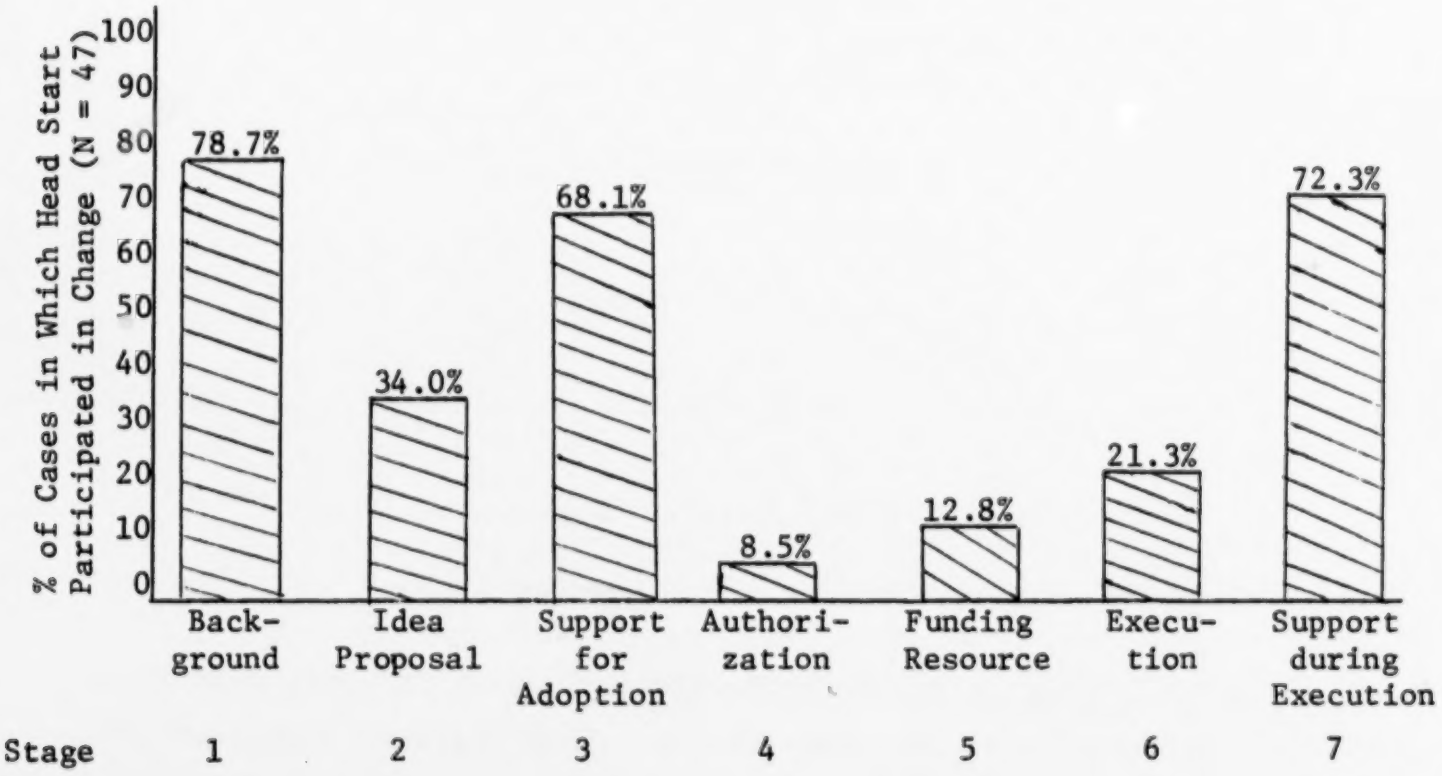
Frequency of Stages in Which Head Start was Involved in the Change Process

Number of Stages in Which Head Start was Involved		Number of Cases	
		f	%
None	0	3	6.4
	1	7	14.9
	2	10	21.3
	3	10	21.3
	4	10	21.3
	5	3	6.4
	6	1	2.0
All	7	3	6.4
Total		47	100.0

Graph S-1 illustrates the proportions of cases in which Head Start was involved at each of the seven stages. Head Start was frequently cited as a background factor (Stage 1) providing the community climate for change. In a number of cases the local Head Start program was given credit for having introduced new concepts into the community and demonstrating that these concepts were feasible and effective. When Head Start contributed to the background for change, it was found to have acted predominantly to focus community attention on a problem and increase the desire for its solution. In 82 percent of all cases, Head Start did this by serving as an example through its own efforts to

solve a problem. In another 59 percent of the cases, Head Start attempted to create a psychological climate for change by intentionally stimulating community concern.

In over one-third of the cases, Head Start parents or staff members were responsible for proposing a change (Stage 2). Head Start staffs have demonstrated support for adoption and execution of changes (Stages 3 and 7) by such activities as assisting in the establishment of new programs and encouraging parents to take advantage of them.



GRAPH S-1: Head Start Participation at Each of Seven Stages of Change Process

In fulfilling its functions of supporting change adoption and cooperating during change execution, Head Start involvement was overwhelmingly that of an active participant. In at least 82 percent of all the cases, Head Start centers used direct, active methods to show

their support for both change adoption and execution. In addition, during change execution Head Start often (in 50 percent of the cases) took advantage of its grass-roots contacts to encourage private individuals and groups to participate in the change. Thus the research data indicate that Head Start frequently played an active role in supporting change. Review of the case studies and the various accounts of Head Start's roles has revealed that Head Start generally had an impact on the institutional change process by pragmatic, quiet actions rather than by violent confrontation.

When the Head Start program has been highly involved in the change process (involved in at least 4 of the seven stages of change) the changes have generally been more positive and of more benefit to the poor than when Head Start was not involved or when it was involved minimally. Three cases, dealing with the same type of change, illustrate this point. The first case shows how a teacher aide program was modified so greatly that poor people could not be employed in it.

> --In a community <u>without a Head Start program</u> public school teachers demanded that the local system hire teacher aides to relieve them of some of their work. The administration and school board were quite willing to go along. State funds were available to finance the aide program and it began during the school year following the negotiations.
>
> At first, widespread satisfaction was expressed over the new aides: the school system saw the program as a solution for its own pressing problems; the low-income community regarded it as a measure that would provide jobs for its people. After a while, however, the program was modified and job descriptions rewritten so that only aides with a level of education well beyond that of most poor persons could be hired. The more stringent qualifications for aide positions could be met only by well-educated, highly motivated, middle-class persons who served as assistant teachers. The poor, few of whom could meet these new qualifications, were, in nearly every case, effectively barred from getting jobs as aides.

Head Start was involved to a minimal degree in the development of another teacher aide program.

--Teacher aides were hired in a southern school system the year that the schools were integrated. Aides were employed mainly for the purpose of doing the extra clerical work that was involved in transferring students' records from black to white schools. Head Start had demonstrated that employment of low-income black people was effective and inexpensive, and, following the example of Head Start, some were employed as aides by the school system. The following year, less money was available for paying teacher aides' salaries, and some of the aides had to be dismissed. It was reported that those who were dismissed were the low-income black people.

A teacher aide program in which Head Start was highly involved developed along strikingly different lines.

--The idea of having aides was proposed by public school teachers who had taught in a local Head Start program. Individuals selected as aides came from the neighborhoods where the schools were located. Thus, teacher aides in the low-income-area schools were low-income people.

School administrators reported that the aides were responsible for a number of positive impacts on low-income children and their parents. A noticeable improvement in the children's motivation and incentive to learn was reported, and the aides appeared to have been more successful than regular teachers in communicating with low-income parents. As a result of the success of the aide program, further changes were being contemplated; school officials had applied for funds to hire community aides from low-income areas to visit in the homes of students and further strengthen the link between the classrooms and impoverished homes.

The impacts of Head Start on institutions did not appear to differ significantly if the local Head Start operation was delegated to a public school system or to a new agency.

--An eastern school system began to employ paraprofessionals as teachers' assistants after public school teachers requested them. The teachers who made these requests had taken leaves of absence from the school system and taught in the CAA-delegated Head Start program where they had gained experience in working with paraprofessionals.

--A school system in a small southwestern town developed a concern for the health needs of poor children as a result of its being delegated to operate the local Head Start. Poor health and nutritional conditions of the Head Start youngsters were discovered during physical examinations performed on the children. School officials realized at that point that local poor families were not utilizing available health facilities and that few of these people visited doctors except when very seriously ill. Subsequently, the school system applied for and received federal funds to hire a school nurse and four nurse's aides. The objective of the nursing program was to identify health problems of school children, notify parents, and insure that cases were followed up.

Certain characteristics of Head Start and the local communities were frequently associated with a high degree of Head Start involvement in change. These characteristics are itemized and defined by example below.

1. A high level of parent participation in the Head Start program, (defined as a high ratio of nonprofessional to professional staff and parental control over the selection of staff members). The examples below typify change processes, first, where "high" parent participation Head Start centers were involved and, second, where the Head Start parent participation level was classified as "low" according to the study's criteria.

--An active Head Start parent group in the Northeast had generated the idea that stimulated the process of setting up a new health clinic.

--In a small midwestern town Head Start parents have little responsibility in the program, and the program appears to be oriented toward providing services rather than organizing parents for community action. A few tangible changes have occurred recently in the delivery of health services (e.g., hours have been changed for the convenience of working people, and service clubs furnish eyeglasses). Head Start roles in bringing about these changes were primarily supportive. For example, the most conclusive evidence of Head Start's participation in these changes was at the final stage (support during change execution), where Head Start was reported to have encouraged families to use the new services.

2. A high degree of visibility of the Head Start program and a willingness by Head Start to relate to other local agencies and institutions.

> --In a western city Head Start programs and methods were well known, and its problems with the school system became public issues important enough to stimulate public action and result in fundamental changes in the school system.

In contrast:

> --A Head Start program in the South has reportedly elected to remain uninvolved with the outside community and channel its efforts entirely into programs for the children. In this community changes have occurred, but the evidence strongly indicated that Head Start had not been involved with any of them.

3. A community climate conducive to change, which in many cases seems to have been brought about by the combination of civil rights activities, the interest and influence of community and professional leaders, and the availability of federal and state funds to meet the needs of poor children.

> --An eastern metropolitan school system has responded to requests from civil rights groups for better educational opportunities. The school system has developed a community schools program which operates in the city's ghettos for people of all ages. This program, particularly the preschool component, is modeled after Head Start and encompasses much of the Head Start theory--employing teacher aides, involving poor people in decision-making, etc. The community school program is financed almost entirely with federal funds.

On the other hand:

> --School officials in a small southern, tradition-oriented community had continuously resisted the use of federal funds and the federal "interference" they felt would accompany them. Since the local school districts could not finance new programs without outside assistance, few if any changes had occurred.

CONCLUSIONS

To appreciate fully the significance of the changes in educational and health institutions noted above, one must view them in perspective. Education and health have traditionally been provinces of professionals, who, somewhat aloof from public contact and control, have protected, taught and disseminated middle-class values for the benefit of middle-class families. In the brief period of less than half a decade, concurrent with the life of Head Start, these institutions have changed remarkably. They have become concerned with the needs and the problems of the poor and of the minorities and have manifested this concern by revising curricula, schedules, approaches, services, etc. They have increasingly involved the public, including the poor, in positions of influence, and they have changed employment criteria so that neighborhood people without professional credentials occupy important paraprofessional positions.

One can truly say that these institutions are still not fully responsive to the poor, that the local commitment to change has not been backed by local dollars, and that the available educational and medical technology is not adequate to the needs. But one cannot deny that in a short time, with a relatively small investment, Head Start has been closely associated on a national basis with the development of fundamental changes in educational and health institutions, two of the most crucial institutional groups in the country. Head Start has been a successful strategy in that it has widely achieved its goals of modifying local institutions so they are more responsive to the needs and desires of the poor.